Medwork Independent Review
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IN PROCESS
Comprehensive
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MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 1/16/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
MRI of right foot/ankle

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas State Licensed MD Board Certified Orthopedic Surgeon

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)
Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY:
The patient was noted to have been injured while working. Reportedly, she had been unloading . The patient's diagnoses had included right ankle sprain and torn lateral ligamentous complex. The history includes that the patient has been documented to be 5 feet 7 inches with a weight of 240 pounds. In addition, history includes that the patient underwent a course of nonoperative treatment and then operative treatment including a Brostrom ligamentous reconstruction in May 2011. Due to clinical issues, the patient reportedly has undergone preoperative MRIs x2 and then postoperative MRIs in August 2012 and again, in August 2014.

A relatively recent clinical note from October 22, 2014, documented peroneal tendon tenderness, along with tenderness at the posterior tibialis and Achilles with a negative squeeze test. There was noted to be severe tenderness to palpation at the plantar fascial band towards the 1st and 2nd digits. There was discomfort upon range of motion of the ankle. The patient was treated with a cortisone injection. Evaluation and treatment as of November 19, 2014, included diffuse symptoms at multiple areas of the foot/ankle despite treatment with a home exercise program and a walking boot, along with NSAIDs. Diagnoses reportedly had included plantar fasciitis, and peroneal weakness, and chronic pes planus. There were no digital records submitted for review.

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ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

There were no physical therapy notes provided for review and no overall details documentation of recent and comprehensive conservative treatment recently provided. In addition, as noted above, the prior MRI studies were not submitted for additional review. The lack of outcomes of comprehensive recent conservative treatment (if applicable) were not provided with regard to pain and/or functionality outcomes with regard to said treatment. Therefore, at this time, the documentation does not evidence as per ODG guidelines an invitation for a repeat MRI due to the lack of significant details, clinical outcomes, and/or recent comprehensive, conservative treatment provided. The significant changes since the last MRI, which was already post-op, has not been provided and therefore, applicable ODG criteria as referenced below in the foot and ankle chapter including the section regarding MRI does not support a repeat MRI of the right foot and ankle at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**